MOTION FILED
MAY - 3 2001

(11)

No. 99-1786

MAY 3 2001

IN THE

# Supreme Court of the United States

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, EARTH SYSTEMS, INC. and THE HEALTH AND WELFARE PLAN FOR EMPLOYEES & DEPENDENTS OF EARTH SYSTEMS, INC.,

*Petitioners,*

*v.*

JANETTE KNUDSON and ERIC KNUDSON,

*Respondents.*

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

## MOTION OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, THE AMERICAN BENEFITS COUNCIL, THE BLUE CROSS BLUE SHIELD ASSOCIATION, THE CHAMBER OF COMMERCE OF THE UNITED STATES, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA FOR LEAVE TO FILE A BRIEF AS *AMICI CURIAE* AND BRIEF OF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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## MOTION FOR LEAVE TO FILE A BRIEF *AMICI CURIAE*

Pursuant to Supreme Court Rule 37, the American Association of Health Plans, the American Benefits Council, the Blue Cross Blue Shield Association, the Chamber of Commerce of the United States, and the Health Insurance Association of America respectfully move this Court to grant them leave to file a brief *amici curiae* in support of Petitioners Great-West Life & Annuity Insurance Company, Earth Systems, Inc., and the Health and Welfare Benefit Plan for Employees and Dependents of Earth Systems, Inc. The *Amici* submit their brief *amici curiae* together with this motion. In support, *Amici* state:

1. Consent of all parties has been requested. Petitioners have consented to the filing of this brief, but Respondents have not. Petitioners' letter of consent accompanies this motion for filing with the Clerk of this Court.

2. *Amicus* the American Association of Health Plans (AAHP) is a national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 health plans serving more than 140 million Americans, the majority of whom are participants or beneficiaries of employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).[1]

---

1. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001 *et seq.*).

3. *Amicus* the American Benefits Council is an organization that advocates for voluntary private employee benefits. Its members sponsor, administer, or service health, retirement and stock compensation plans covering more than 100 million Americans.

4. *Amicus* the Blue Cross Blue Shield Association comprises forty-five independent, locally operated Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies provide health care coverage to private and public employees and individuals, through relationships with employers, employee benefits plans, and direct contracts with subscribers. They offer health insurance, fee-for-service programs, health maintenance organizations, preferred provider organizations, and a variety of other offerings. They also provide third-party administrative services to private and public employee benefits plans. Collectively, the Blue Cross Blue Shield companies furnish health care coverage to 78 million — or one in four — Americans, making them collectively the largest entity offering health insurance and benefits in the United States.

5. *Amicus* the Chamber of Commerce of the United States (the Chamber) is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations with 140,000 direct members of every size, in every business sector, and from every geographic region of the country. An important function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of concern to the American business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital importance to them, their employees, the employees' dependents, and to the Chamber.

6. *Amicus* the Health Insurance Association of America (HIAA) is a national association of private health insurance companies and an advocate for the private, market-based insurance system. HIAA's more than 294 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to approximately 123 million Americans.

7. *Amici* are concerned by the Ninth Circuit's holding in the case below, which essentially vitiates reimbursement provisions that are commonly included in employee health benefit plans which are offered by their member organizations, or which they insure or administer. The Ninth Circuit's holding runs contrary to ERISA's mandate that a fiduciary administer an ERISA plan "in accordance with the documents and instruments governing the plan." It also interferes with nationally uniform plan administration by making plans subject to different legal obligations in different federal circuits and by subjecting plans to varying state laws, undermining the carefully balanced congressional scheme and increasing compliance costs. Most critically in a time of tight healthcare budgets, it will have a drastically adverse effect on the ability of the employee benefit plan community and the health care industry to provide quality care at an affordable cost.

8. In filing this brief, *Amici* seek to bring to the attention of this Court relevant matters not already brought to its attention by the parties, including but not limited to the disastrous

national impact of the lower court's decision on the health insurance and employee welfare benefit plan industry at large.

For the above reasons, *Amici* respectfully request this Court to grant leave to file their brief *amici curiae*.

Respectfully submitted,


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## BRIEF OF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

## I. STATEMENT OF INTEREST[1]

The American Association of Health Plans (AAHP) is a national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 health plans serving more than 140 million Americans, the majority of whom are participants or beneficiaries of employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA).[2]

The American Benefits Council is an organization that advocates for voluntary private employee benefits. Its members sponsor, administer, or service health, retirement and stock compensation plans covering more than 100 million Americans.

The Blue Cross Blue Shield Association comprises forty-five independent, locally operated Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield companies provide health care coverage to private and public employees and individuals, through relationships with employers, employee benefits plans, and direct contracts with subscribers. They offer health insurance, fee-for-service programs, health maintenance organizations, preferred provider organizations, and a variety of other offerings. They also provide third-party administrative services to private and public employee benefits plans. Collectively, the Blue Cross Blue Shield companies furnish health care coverage to 78 million — or one in four — Americans, making them collectively the largest entity offering health insurance and benefits in the United States.

1. Counsel for *Amici* were the sole authors of this brief. No person or entity other than *Amici* made financial contribution to this brief.

2. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001 *et seq.*).

The Chamber of Commerce of the United States (the Chamber) is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations with 140,000 direct members of every size, in every business sector, and from every geographic region of the country. An important function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of concern to the American business community. Many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans regulated under ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is of vital important to them, their employees, the employees' dependents, and to the Chamber.

The Health Insurance Association of America (HIAA) is a national association of private health insurance companies and an advocate for the private, market-based insurance system. HIAA's more than 294 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to approximately 123 million Americans.

*Amici* are concerned by the Ninth Circuit's holding in the case below, which essentially vitiates reimbursement provisions that are commonly included in employee health benefit plans which are offered, insured, or administered by their member organizations. Petitioners have consented to *Amici* filing this brief but Respondents have not. The Court of Appeals erred in holding that the reimbursement of payments made to an ERISA plan beneficiary did not constitute "appropriate equitable relief" within the meaning of ERISA Section 502(a)(3). The Petitioners here properly sought to rely on that Section, which allows actions "(A) to enjoin any act or practice which violates . . . the terms of the plan, or (B) to obtain other appropriate equitable relief:



(i) to redress such violations; or (ii) to enforce any provisions . . . or the terms of the plan."[3]

In preventing an ERISA fiduciary from obtaining reimbursement out of a tort recovery of medical expenses that the plan has paid on behalf of a participant or beneficiary, the lower court has in effect nullified a critical plan provision by judicial fiat. Its holding has the following adverse effects:

- It allows noncompliant participants or beneficiaries to be unjustly enriched at the expense of their fellow participants and beneficiaries;
- It disincentivizes employers from sponsoring and funding employee benefit plans;
- It interferes with nationally uniform plan administration by making health benefit plans subject to different legal obligations in different federal circuits; and
- It forces a fiduciary to contravene ERISA's mandate that a plan be administered in accordance with plan documents.[4]

Because health plans recoup significant amounts of money under reimbursement provisions, the Ninth Circuit's decision will drastically and adversely affect the ability of the employee benefit plan community and the health care industry to provide, administer, fund and arrange for appropriate and affordable care in a time of rising health care costs. This country's health care financing system depends on effective cost-containment practices, including reimbursement provisions, to ensure the wise use of limited health care dollars and to ensure employers' economic support of employee benefit plans.

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3. Employee Retirement Income Security Act of 1974 (ERISA) § 502(a)(3), 29 U.S.C. § 1132(a)(3) (1994).

4. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

## II. SUMMARY OF ARGUMENT IN SUPPORT OF PETITIONERS' BRIEF ON THE MERITS

In the case below, the Ninth Circuit essentially held that a beneficiary did not have to reimburse her employee health benefit plan for expenses provided her from a third party recovery, despite an explicit reimbursement clause in the plan documents mandating such reimbursement. Adopting an aberrational construction of equitable relief, the court held that the enforcement of such reimbursement provisions necessarily constituted "legal" damages rather than "equitable" relief within the meaning of ERISA Section 502(a)(3)(B).[5] Not only is there no precedent to support the Ninth Circuit's novel interpretation of what constitutes "equitable" relief, but the precedent of this Court is directly contrary.[6] Moreover, no other federal circuit court espoused such a rigid definition of equitable relief, and in fact all other circuits which have considered the issue have explicitly rejected the underlying reasoning.[7]

5. *Great-West Life & Annuity Ins. Co. v. Knudson*, No. 98-56472, 2000 WL 145374 at *1 (9th Cir. Feb. 7, 2000) (citing ERISA § 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B)).

6. *See Mertens v. Hewitt Assocs.*, 508 U.S. 248, 256 (1993) (finding appropriate "equitable relief" as used in Section 502(a)(3) means "those categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)"); *Harris Trust & Sav. Bank v. Salomon Smith Barney, Inc.*, 530 U.S. 238, 252-53 (2000) (equitable remedy of constructive trust could be applied to recover money for a plan from a party); *Local No. 391 v. Terry*, 494 U.S. 558, 570 (1990) (refusing to hold that "any award of monetary relief must *necessarily* be 'legal relief'", and noting that damages can be equitable "where they are restitutionary" (citing *Curtis v. Loether*, 415 U.S. 189, 196 (1974)) (further citations omitted)).

7. *See Wal-Mart Stores, Inc. Assocs.' Health & Welfare Plan v. Wells*, 213 F.3d 398, 401 (7th Cir. 2000); *Administrative Comm. v.* (Cont'd)



By writing out of the statute the ability of fiduciaries to use Section 502(a)(3) to enforce plan reimbursement clauses, the Ninth Circuit's holding leaves fiduciaries in a bind, with no alternative remedies either under ERISA or under state law. No other provision of ERISA can be construed to provide the necessary relief to a plan whose reimbursement clause is rendered a nullity. Moreover, because ERISA provides that federal courts shall have exclusive jurisdiction over enforcement of plan terms, plans have no alternative forum, as they cannot enforce their reimbursement rights in the state courts.[8]

In essence, the Ninth Circuit's holding does violence to the text of ERISA in that it: (1) bars fiduciaries from seeking relief under ERISA Section 502(a)(3), contrary to the statute's specific language; and (2) contravenes ERISA's Section 404(a)(1)(D) requirement that an employee benefit plan be administered in accordance with its governing documents.

Not only is the lower court's interpretation contrary to the language of the statute, but it contravenes *every one* of

(Cont'd)
*Gauf*, 188 F.3d 767, 770-71 (7th Cir. 1999); *Health Care Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703, 711 (7th Cir. 2000); *Southern Council of Indus. Workers v. Ford*, 83 F.3d 966, 969 (8th Cir. 1996) (per curiam); *Blue Cross & Blue Shield v. Sanders*, 138 F.3d 1347, 1352-53 n.5 (11th Cir. 1998).

8. *See, e.g., Jefferson-Pilot Life Ins. Co. v. Krafka*, 57 Cal. Rptr. 2d 723 (Ct. App. 1996) (finding plan's state court reimbursement claims preempted by ERISA); *see also Carpenters Health v. McCracken*, 100 Cal. Rptr. 2d 473, 476 (Ct. App. 2000) ("Taken together, *Krafka* and [*FMC Medical Plan v.*] *Owens* [122 F.3d 1258 (9th Cir. 1997)] place a plaintiff seeking reimbursement under the terms of an employee benefit plan in a Catch 22. Under *Krafka*, the plaintiff must pursue its reimbursement claim in federal court. Under *Owens*, by contrast, the plaintiff must pursue its reimbursement claim in state court.").

what this Court has called the sometimes "competing congressional purposes" for enacting ERISA in the first place.[9] Those purposes include the desire to: (1) protect plan participants and beneficiaries,[10] (2) assure uniformity and efficiency in plan administration,[11] and (3) create incentives for the creation and maintenance of employee benefit plans.[12] As outlined below, every one of those congressional goals would be frustrated here by allowing the lower court decision to stand.

In sum, the Ninth Circuit's decision: (1) hinders plan sponsors, plan fiduciaries, and managed care organizations from including reimbursement provisions in their contracts, thereby implementing legitimate and necessary strategies to prevent the unnecessary dissipation of a limited pool of health care funds; (2) allows plan participants and beneficiaries to

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9. *Varity Corp. v. Howe*, 516 U.S. 489, 507 (1996).

10. *See Boggs v. Boggs*, 520 U.S. 833, 845 (1997) ("The principal object of the statute is to protect plan participants and beneficiaries.") (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)). The statute itself notes that the express purpose is "to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. § 1001(b).

11. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995).

12. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987) ("A patchwork scheme of regulation would introduce considerable inefficiencies in the benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them."). Additionally, the U.S. Internal Revenue Code provides incentives both for employers to establish qualified benefit plans as well as for employees to participate in them, because a contribution to a qualified plan is immediately deductible by the employer and only becomes taxable to the employee on subsequent distribution. I.R.C. § 404.



collect windfall payments at the expense of the majority of their co-participants in the same benefit plan; (3) creates an administrative burden for plan administrators and increases costs and delays by requiring them to follow different reimbursement provisions depending on the circuit; and (4) ultimately will lead to increases in health benefit plan costs, discouraging employers and others from maintaining benefit plans, and inevitably increasing the ranks of the uninsured.

## III. ARGUMENT

### A. Reimbursement Provisions Are Critical Cost Saving Measures Designed to Benefit All Plan Participants and Beneficiaries

#### 1. Reimbursement Provisions Ensure That Health Coverage Remains Affordable

Reimbursement provisions such as those at issue in this case are used extensively throughout the insurance and managed care industries, and have been in continuous use since the passage of ERISA. Such provisions generally require a plan participant or beneficiary to reimburse the plan for funds expended on the beneficiary's behalf, if the beneficiary recoups money from a third party responsible for the beneficiary's injuries.

Reimbursement provisions serve several important goals, including: (1) preventing participants and beneficiaries from retaining double recoveries and thus conserving limited plan funds; (2) preventing responsible parties such as tortfeasors from profiting from the existence of participants' and beneficiaries' health care cove~~rage~~; and (3) limiting the age-old moral hazard problem, whereby participants and

beneficiaries alter their behavior because of the presence of insurance or other coverage.[13]

Functionally, reimbursement provisions operate to allow insurance companies and health benefit plans to recoup funds directly from participants or beneficiaries who ultimately recover payments for the same injuries from responsible third parties. Reimbursement differs from the more expensive alternative of subrogation, in that under a reimbursement provision, a health benefit plan does not actually commence an action in the beneficiary's name, as it would under a subrogation provision, but instead acts as a first lienholder upon any third-party funds collected by the beneficiary.

Private insurers have been relying on reimbursement mechanisms since at least the mid-eighteenth century to ensure that coverage remains accessible and affordable for all.[14] Such provisions are also utilized by public payors. For example, the federal Medicare Secondary Payor provisions require Medicare beneficiaries to reimburse Medicare for expenses later paid by liability insurance or automobile

13. The moral hazard concern is particularly at issue in this case, where the Respondent Ms. Knudson settled the prior medical expense portion of her original claims for only $13,828.70, knowing that Petitioners had covered her medical expenses which amounted to in excess of $400,000.

14. *See* M. L. Marasinghe, *An Historical Introduction to the Doctrine of Subrogation: The Early History of the Doctrine I*, 10 VAL. U.L. REV. 45 (1975); *see also Randal v. Cockran*, 1 Ves. Sen. 98, 27 Eng. Rep. 916 (Ch. 1748) (Lord Hardwicke finding "the plainest equity that could be" where "[t]he person originally sustaining that loss was the owner, but after satisfaction made to him, the insurer. No doubt, but from that time, as to the goods themselves, if restored in *specie, or compensation made for them*, the assured stands as a trustee for the insurer, in proportion for what he paid." (emphasis added)).



insurance.[15] Any Medicare payment made with respect to any item or service for which payment has been made, or can reasonably be expected to be made promptly by a third party payor, is conditioned on reimbursement to the appropriate Trust Fund. With very limited exceptions, this provision allows Medicare to recover fully and directly from beneficiaries for liabilities paid by third party payors, without regard to whether the beneficiaries accepted discounted settlements.[16]

**2. Plan Fiduciaries and Administrators Are Obligated to Employ Reimbursement Provisions to Conserve Limited Plan Assets**

Reimbursement provisions are critical cost-savings devices for employers and other plan sponsors facing strong health care cost inflation pressures. As this Court explicitly recognized in *Pegram v. Herdrich*,[17] systems for the achievement of cost savings in health care coverage and delivery have constituted a key part of federal and state health care programs since the passage of the Federal Health Maintenance Organization Act of 1973,[18] and indeed Congress has legislated since that time in the area of cost-containment mechanisms.[19]

15. *See* 42 U.S.C. § 1395y(b)(2)(B) (1994 & Supp. V 2000).

16. *See* 42 C.F.R. § 411.35 (2000); *Zinman v. Shalala*, 67 F.3d 841, 845 (9th Cir. 1995) (holding that the Medicare Secondary Payor provisions allow the U.S. Department of Health and Human Services to recover full reimbursement of conditional Medicare payments from beneficiaries, even though the beneficiaries received discounted settlements from third parties).

17. 530 U.S. 211, 233 (2000).

18. 42 U.S.C. § 300(e).

19. *See, e.g.*, the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 2945, (codified as amended at 42 U.S.C. § 1301 *et seq.*), which limited the use of pre-existing condition exclusions.

Millions and potentially billions of dollars are recouped annually by health plans and insurers by virtue of subrogation and other recovery mechanisms.[20] Reimbursement provisions are designed to protect *all* beneficiaries' interests by ensuring that plan funds are used prudently, and, in the words of the statute, for the "exclusive purpose of . . . providing benefits to participants and their beneficiaries; and . . . defraying reasonable expenses of administering the plan."[21]

ERISA and the law of trusts[22] require plan fiduciaries to manage the assets of their health plans prudently and in the best interests of all beneficiaries,[23] and "to act to ensure that a plan receives all funds to which it is entitled, so that those funds can be used on behalf of participants and beneficiaries."[24] The statute uses the plural deliberately — the interests of those plan members in the aggregate are paramount, and one member should not be allowed to benefit disproportionately at the expense of the group. In fact, each of those trust beneficiaries owe each other a fiduciary duty not to take advantage of the others.[25]

20. During fiscal year 2000, Healthcare Recoveries, Inc., one of the largest private health care claims recovery services in the United States, recovered $237.3 million in health claims, and had a backlog of over $1.1 billion of potentially recoverable claims. *See* Healthcare Recoveries, Inc., Form 10-K, for the fiscal year ended Dec. 31, 2000, at 20.

21. ERISA § 404(a)(1)(A), 29 U.S.C. § 1104(a)(1)(A).

22. This Court has held that the common law of trusts is incorporated in ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3). *See Harris Trust & Sav. Bank*, 530 U.S. at 250.

23. ERISA § 404(a)(1)(B), 29 U.S.C. § 1104(a)(1)(B).

24. *See Central States Pension Fund v. Central Transp., Inc.*, 472 U.S. 559, 571 (1985).

25. *See* GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, THE LAW OF TRUSTS AND TRUSTEES § 191 (rev. 2d ed. 1979); RESTATEMENT (SECOND) OF TRUSTS §§ 251-255 (1959).



The lower court's holding, however, erects an insurmountable roadblock, preventing ERISA plan fiduciaries from complying with their duty to be financially prudent and seek recovery of plan funds where available.[26] It also allows a few ERISA beneficiaries to be unjustly enriched at the expense of their fellow plan beneficiaries.

### 3. The Ninth Circuit's Decision Will Inevitably Increase Health Benefit Costs and Increase the Ranks of the Uninsured

The Ninth Circuit's holding rendering health plan reimbursement provisions a nullity and precluding employee health benefit plans from recovering from third-party payments necessarily drains plan funds. Health benefit plans can be insured either through a risk-bearing mechanism or self-insured, and hence reliant on employer assets to pay charges for health care, as was Ms. Knudson's plan.[27] In either case, they must charge premiums commensurate with that risk, or adequate to ensure that funds will be available for services needed by employees and their dependents.[28]

Insurance companies and employee health benefit plans base rates and benefit levels on actuarial determinations that factor in the effect of subrogation and reimbursement provision recoveries.[29] Should plans be barred from seeking

26. *See Varity Corp.*, 516 U.S. at 514; *Liss v. Smith*, 991 F. Supp. 278, 290 (S.D.N.Y. 1998).

27. As this Court summarized in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985), employee welfare plans "may self-insure or they may purchase insurance for their participants."

28. *See* SHERYL TATAR DASCO & CLIFFORD C. DASCO, MANAGED CARE ANSWER BOOK 3-40 (3d ed. 1999).

29. *See e.g.* DOCUMENTATION IN HEALTH BENEFIT PLAN RATEMAKING, Actuarial Standards of Practice No. 31, § 3.5.4 (Actuarial Standards Bd. 1997).

reimbursement from members that have been doubly indemnified for their damages, those actuarial assumptions are rendered invalid. That loss of predictability makes rate-setting difficult or impossible, and, when combined with the inability to recoup plan funds, the inevitable result will be that rates will ultimately increase and/or benefits will decrease for all members of employee health benefit plans.

After a period of relatively stable health care costs, employers are once again facing health care inflation. Such inflation is attributable to a variety of factors, including changes in medical practice, the development of expensive new technologies, and greater use of prescription drugs and other services.[30] To cope with those rising costs, employers are working with insurers and health plans[31] to control health care costs[32] through the management of health care, including the use of cost containment mechanisms such as reimbursement.

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30. *See Hearing on the Relationship Between Health Care Costs and America's Uninsured Before the Subcomm. on Employer-Employee Relations of the House Comm. on Educ. & the Workforce*, 106th Cong. 55, 60 (statement of Dan Crippen, Director, Congressional Budget Office) [hereinafter *Hearings*]. *See generally* HEALTH INS. ASS'N OF AM., ISSUE BRIEF: WHY DO HEALTH INSURANCE PREMIUMS RISE? (2000).

31. *See Hearings*, *supra* note 30, at 58-59; HEALTH INS. ASS'N OF AM., *supra* note 30, at 18-19.

32. *See generally* Jack Zwanziger & Glenn A. Melnick, *Can Managed Care Plans Control Health Care Costs?*, HEALTH AFFAIRS, Summer 1996, at 185, 196 (concluding that "the failure of governmental health care reform leaves the primary responsibility of increasing the efficiency of the health care system to the private sector. The studies summarized [in this article] strongly suggest that managed care plans have been successful in inducing price competition and forcing costs down.").



According to the Mercer/Foster Higgins annual *National Survey of Employer-Sponsored Health Plans*, costs of employee health benefit plans increased 8.1% during calendar year 2000, more than twice the rate of general inflation.[33] Similarly, the Kaiser Family Foundation and the Health Research and Educational Trust determined that employee health benefit plan and insurance premiums increased 8.3% from the Spring of 1999 to the Spring of 2000, outpacing the inflation rate by more than 5%,[34] and a survey by the Towers Perrin consulting firm found that cost increases for employee health benefit plans in 2000 averaged 10%, compared to inflation of only 3.4%.[35]

The costs of employee health benefit plans are projected to again increase significantly during 2001. Mercer/Foster Higgins projects that average cost increases in employee health benefit plans will be 11%,[36] and the Washington Business Group on Health and Watson Wyatt Worldwide projects average increases of 12.2%.[37]

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33. William M. Mercer, Inc., *Employers Bracing for Double-Digit Health Benefit Cost Rise in 2001*, MERCER REP., Jan. 12. 2001, at 1, 1 (summarizing survey results from the William M. Mercer, Inc. & Foster Higgins, *National Survey of Employer-Sponsored Health Plans 2000*. Over 3,300 employers responded to the Mercer/Foster Higgins survey, and the results are statistically projectable to all U.S. employers that employ ten or more employees and offer health benefits).

34. KAISER FAMILY FOUND. (KFF) & HEALTH RESEARCH & EDUC. TRUST (HRET), EMPLOYER HEALTH BENEFITS, 2000 ANNUAL SURVEY 12 (2000). The survey found that the inflation rate during this time was 3.0%.

35. TOWERS PERRIN, 2001 HEALTH CARE COST SURVEY, REPORT OF KEY FINDINGS 5 (2001) (221 employers responded to the Towers Perrin survey).

36. William M. Mercer, Inc., *supra* note 33, at 1.

37. WASHINGTON BUSINESS GROUP ON HEALTH & WATSON WYATT WORLDWIDE, HEALTH CARE COSTS 2001 2 (2001).

As costs rise, employers must necessarily limit benefits, limit or even end their support of health and welfare plans, or pass cost increases on to employees. None of those results are optimal at a time when an estimated 43 million Americans are uninsured.[38] Cost containment mechanisms such as reimbursement provisions are critical to ensure that the number of privately insured individuals does not decrease.[39] Studies have shown that employers and health care beneficiaries are highly price sensitive,[40] and increasing the cost of health care coverage will ultimately lead to a corresponding decrease in the number of covered individuals.[41] Even a one percent increase in managed care plans' costs nationally "results in a potential loss of insurance coverage for about 315,000 individuals" over a five-year period.[42] The Ninth Circuit's decision to disallow enforcement of reimbursement provisions in ERISA plans will force the price of coverage up, and ultimately cause more Americans to be uninsured.

Employer-based health insurance is the keystone of the American health care system. In 1999, over 70% of people in the United States had some kind of private health coverage[43] and over 60% of that coverage was employer-

38. *See* ROBERT J. MILLS, CENSUS BUREAU, U.S. DEP'T OF COMMERCE, P60-211, CURRENT POPULATION REPORTS: HEALTH INSURANCE COVERAGE 1999 1 (2000).

39. *See Hearings*, *supra* note 30, at 63.

40. *See* Zwanziger & Melnick, *supra* note 32, at 190-91.

41. *See id.*; KFF & HRET, *supra* note 34, at 164; HEALTH ECON. PRACTICE GROUP, BARENTS GROUP, LLC, IMPACTS OF FOUR LEGISLATIVE PROVISIONS ON MANAGED CARE CONSUMERS: 1999–2003 iii (prepared for the Am. Ass'n of Health Plans, 1998); *Hearings*, *supra* note 30, at 62-63.

42. *See* HEALTH ECON. PRACTICE GROUP *supra* note 41, at iii.

43. *See* MILLS, *supra* note 38, at 3.



based.[44] As the number of privately insured individuals decreases, the financial burden of health care may shift to the already-strained federal and state systems.[45] National public policy is clearly against altering the health insurance and ERISA plan industry in any way that would significantly increase premium and deductible rates. The Ninth Circuit's decision below, in shifting to plan participants the burden of the medical expenses caused by a tortfeasor who had insured himself against just such a contingency, serves no clear public policy purpose.

### B. The Ninth Circuit's Holding Contravenes Every One of ERISA's Purposes

#### 1. The Ninth Circuit's Decision Harms Plan Participants and Beneficiaries.

Should the Ninth Circuit believe that it is helping individual plan participants or beneficiaries retain additional monies by invalidating reimbursement clauses, it could not be more wrong. In fact, a plan's enforcement of its reimbursement clause simultaneously serves the interest of both the plan and the beneficiary, unlike the more common situation where there is "tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing . . . costs."[46]

44. *See id.* at 1.

45. *See* JOHN SHEILS & LISA ALECXIH, LEWIN GROUP, INC., RECENT TRENDS IN EMPLOYER HEALTH INSURANCE COVERAGE AND BENEFITS, FINAL REPORT 7 (1996) (projecting that as the percentage of people with employer-sponsored health care as their primary health care coverage decreases, the percentage of people with Medicare or Medicaid as their primary source of health care coverage will increase).

46. *Mertens*, 508 U.S. at 262-263 (citing *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981)).

When operational, reimbursement provisions prevent double payment for the same claim, and ensure that the liability for tort claims fall on those who cause injury rather than innocent plan beneficiaries.[47] The Ninth Circuit's decision potentially penalizes Ms. Knudson's fellow beneficiaries in at least three ways: (1) other group beneficiaries might choose to ignore plan language and their reimbursement obligation on a selective basis, as Ms. Knudson did; (2) premiums or contributions to the health benefit plan may rise, as the need arises to make up the shortfalls paid out to Ms. Knudson and others like her; and (3) the employer sponsor may decide to either cut back its contribution (again, requiring an increase in premiums) or eliminate the health benefit plan altogether.[48]

Barring enforcement of a plan reimbursement provision constitutes unjust enrichment of one participant or beneficiary at the expense of the group. Individuals, their family members, and their fellow co-workers may be subjected to a scenario where too few resources exist for health care expenses at a later date, or, in the extreme case, where an employer may decide to limit benefits or cancel its sponsorship of a benefit plan altogether.

In health care, as in all other aspects of the economy, the pool of dollars is necessarily limited, and a windfall to one plan member must inexorably come out of the pockets of the rest, either directly through higher premiums,

47. *See Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 712.

48. *See Hearings*, *supra* note 30, at 62-63 (stating that employers would respond to increased costs by being less generous with coverage, raising cost-sharing requirements, or even eliminating benefits or dropping coverage completely. Employees would respond to rising health insurance costs by dropping coverage as premiums increase, or selecting less generous coverage.).



deductibles, and copays, or indirectly through reduced benefits. In sum, upholding the Ninth Circuit's *Knudson* decision will serve to pit plan beneficiaries against each other, and defeat, rather than advance the congressional goal of protecting "the interests of participants in employee benefit plans and their beneficiaries."[49]

### 2. The Invalidation of Plan Reimbursement Provisions Creates Disincentives to Employer Funding of Benefit Plans

Sustaining the holding of the Ninth Circuit with respect to health benefit plan reimbursement provisions will considerably reduce the incentives of plan sponsors such as employers to sponsor and/or fund health care for their employees, and increase costs for them and ultimately the plan participants as well. This Court has been adamant that ERISA not be interpreted in a manner which "create[s] a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit benefits in the first place."[50]

There is no legal mandate to sponsor such plans, nor is there any mandate regarding "what kind of benefits employers must provide if they choose to have such a plan."[51] Instead, employers voluntarily support this nation's employer-based private health care coverage system.[52] Such employer-sponsored plans are critical: of all individuals

49. 29 U.S.C. § 1001(b); *see Boggs*, 520 U.S. at 845 ("The principal object of the statute is to protect plan participants and beneficiaries").

50. *Varity Corp.*, 516 U.S. at 497.

51. *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996).

52. *See Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995).

living in families headed by a worker, 68% live in households where the family head receives coverage through an employer.[53] Among such households, 88% of individuals receive employment-based coverage.[54]

In the case of Ms. Knudson, her medical bills were advanced to her by the Petitioners pursuant to the agreement that the self-funded plan would have the first lien and be reimbursed out of any tort recovery. The holding below will inevitably and materially increase premium costs for those employers willing to sponsor ERISA plans, and those costs will likely be passed on to their employees and those who purchase their products and services.[55]

### 3. The Ninth Circuit's Decision Prevents Uniform Administration of Multistate Employee Benefit Plans

The Ninth Circuit's position on the nonenforceability of reimbursement clauses is unique: it is contrary to the position of every other federal circuit that reimbursement provisions are enforceable equitable relief under ERISA.[56] Only ERISA plan participants litigating in that particular circuit are entitled to disregard plan contractual language and recover more than they are entitled to, while participants in every other circuit are bound by the reimbursement terms of their plans.

53. *See* William S. Custer & Pat Ketsche, Center for Risk Mgmt. & Ins. Research, Georgia State Univ., Employment-Based Health Insurance Coverage 7 (Health Ins. Ass'n of America, 2000).

54. *See id.*

55. *See* William M. Mercer, Inc., *supra* note 33, at 1.

56. *See, e.g.*, *Wal-Mart Stores, Inc.*, 213 F.3d at 401; *Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 710; *Blue Cross & Blue Shield*, 138 F.3d at 1352-53 n.5; *Southern Council of Indus. Workers*, 83 F.3d at 969; *Harris Trust & Sav. Bank v. Provident Life & Accident Ins. Co.*, 57 F.3d 608, 615-16 (7th Cir. 1995).



Vitiating such reimbursement provisions in one circuit and one circuit only disrupts any federal attempt at uniform plan regulation.[57] ERISA was intended "to ensure that plans and plan sponsors would be subject to a uniform body of benefits law," and thus "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government."[58] Clearly, denying ERISA plans in the Ninth Circuit the right to enforce reimbursement provisions under Section 502(a), 29 U.S.C. § 1132(a), results in the complete abrogation of their rights in one particular area of the country and hence non-uniform enforcement.

Like the state statute revoking the designation of a spouse as life insurance beneficiary automatically upon divorce which was struck down by this Court recently in *Egelhoff v. Egelhoff*, the Ninth Circuit's holding impacts "a central matter of plan administration."[59] That "central matter" pertains to the essence of health coverage: both the ability to access it subsequent to an accident that results in medical bills, and the ability to afford it both now and in the long run. Thus, a beneficiary may find that the plan has not advanced medical expenses because of the impossibility of recovery of those expenses out of an ensuing tort settlement. Or a plan may find that it is unfortunately enmeshed in expensive litigation instead of the simple automatic lien on recovery called for in the plan documents — costs that

57. *See FMC Corp. v. Holliday*, 498 U.S. 52, 58-60 (1990).

58. *New York State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 656 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)); *see Egelhoff v. Egelhoff*, No. 99-1529, slip op. at 6-7 (U.S. Mar. 21, 2001) ("Uniformity is impossible, however, if plans are subject to different legal obligations in different States."); *Fort Halifax Packing Co.*, 482 U.S. at 9; *see also Shaw*, 463 U.S. at 99.

59. *Egelhoff*, No. 99-1529, slip op. at 6.

inevitably will be passed on to employees and their families in the form of higher premiums. Such litigation ultimately transfers to plan beneficiaries and their families the "costs of delay and uncertainty"[60] that arise from forcing plan administrators to weigh alternate options for recovery, if any, such as pursuing the far more expensive remedy of traditional subrogation.[61]

As in *Egelhoff*, "the burden is exacerbated by the choice-of-law problems that may confront an administrator" when the relevant parties are located in different states.[62] Here, an employer may sponsor a plan from its headquarters in Connecticut, retaining fiduciary responsibilities, while its claims administrator is located in Pennsylvania, and the beneficiary may be from Kansas. Yet if the tort judgment has been rendered in California solely because it was the situs of the automobile accident involving that beneficiary, who was in California on vacation, the Ninth Circuit's peculiar rule applies. The substantial administrative uncertainties created by such a scenario are evident for ERISA plan sponsors, plan fiduciaries, and beneficiaries.

The Ninth Circuit rule may inspire a less than scrupulous beneficiary, moreover, to deliberately choose a venue for filing a tort suit within that Circuit's jurisdiction to take advantage of the "no reimbursement" rule. The federal courts should not encourage plaintiffs to forum shop by allowing plaintiffs to determine the venue of potential tort actions at the expense of their employers and fellow beneficiaries.

60. *Id.* at 7.

61. Subrogation may not be available as a alternative remedy in all situations. For example, many states prohibit health plan subrogation, *see, e.g.*, CONN. GEN. STAT. § 52-225c (2000); GA. CODE. ANN. § 33-24-56.1(e) (2000); VA. CODE. ANN. § 38.2-3405 (Mitchie 2000), and some plans may not provide for subrogation.

62. *Egelhoff*, No. 99-1529, slip op. at 7.



In sum, the lower court's decision "would undermine the congressional goal of 'minimiz[ing] the administrative and financial burden[s]' on plan administrators — burdens ultimately borne by the beneficiaries."[63]

### C. The Ninth Circuit's Decision Forces a Plan to Violate ERISA's Mandate That a Plan be Administered in Accordance With Its Documents and Instruments

The plan documents at issue in the case below expressly entitled the plan to reimbursement for medical expenses that were paid on behalf of Ms. Knudson.[64] ERISA provides that every employee benefit plan be established pursuant to a written instrument and that named fiduciaries control and manage the operation and administration of the plan.[65] The statute's participant protections attempt to ensure that the appointed plan administrators and fiduciaries implement the plan "in accordance with the documents and instruments governing the plan."[66] Despite the explicit language of the statute that plan fiduciaries must have access to the federal courts to enforce plan terms and redress violations of those plans, the Ninth Circuit has effectively left them without a remedy by denying them access to the federal courts to enforce reimbursement provisions.

In enacting ERISA, Congress did not intend that the federal judiciary substitute its views as to what constitutes appropriate plan design for the judgments of employers and plan sponsors. Yet the Ninth Circuit's decision in this case in fact arrogates to the federal judiciary the power to rewrite

63. *Egelhoff*, slip op. at 7-8 (quoting *Ingersoll-Rand Co.*, 498 U.S. at 142).

64. *See* Pet. for Writ of Certiorari at 5.

65. ERISA § 402(a)(1), 29 U.S.C. § 1002(a)(1).

66. *Egelhoff*, No. 99-1529, slip op. at 5; ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D).

the terms of health benefit plans — to eliminate one particular cost-saving mechanism, namely the reimbursement provision.

It is not for the federal courts to second-guess legislatively-determined health care policy issues, as this Court pointed out in *Pegram v. Herdrich*.[67] Here, the lower court has substituted its views as to appropriate plan design for the collective judgments of Congress as expressed in ERISA, employers, fiduciaries, and plan sponsors. The foundation of the United States' voluntary, employer-based healthcare system is the ability to design benefit plans with cost-containment mechanisms including reimbursement, free of such interference by the courts, yet the Ninth Circuit seeks to undermine this foundation.

Most disturbing is the Ninth Circuit's willingness to disrupt this foundation based on its anything-but-traditional rewriting of the law of equity to find that a claim for monetary relief is automatically a claim for legal damages that cannot be brought under ERISA Section 502(a)(3). That Court, uniquely, has refused to accept the uniform consensus that monetary relief is not necessarily "legal" relief. Other federal circuit courts that have grappled with the question of how to enforce plans' reimbursement provisions have applied equitable remedies to allow employee health benefit plans to be effectively reimbursed under ERISA. Some have chosen to apply a constructive trust remedy in resolving this issue,[68] while others have chosen alternative rubrics such as specific performance.[69] In addition

67. 530 U.S. 211, 235-37 (2000).

68. *See Wal-Mart Stores, Inc.*, 213 F.3d at 401-02; *Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 710-11.

69. The Eleventh Circuit in *Blue Cross & Blue Shield v. Sanders* relied on precedent that "[s]pecific performance is an equitable remedy available when legal remedies are inadequate" and that "'equitable (Cont'd)



to remedies applied by such courts, a variety of other equitable remedies might be available, such as imposing an equitable lien on the beneficiary's tort recovery, or a mandatory injunction directing the beneficiary to sign over the claim.[70]

(Cont'd)
relief' under § 1132(a)(3)(B) includes monetary awards typically available in equity but not compensatory or consequential damages." *Blue Cross & Blue Shield*, 138 F.3d at 1352-53 n.5 (citing *Dairy Queen, Inc. v. Wood*, 369 U.S. 469, 478 (1962)).

70. *See Health Care Cost Controls of Ill., Inc.*, 187 F.3d at 711. Even should this Court choose to find no relief for Petitioners available under ERISA Section 502(a)(3), 29 U.S.C. § 1132(a)(3), *Amici* urge that it find relief available under an alternative cause of action as a matter of federal common law. *See Provident Life & Accident Ins. Co. v. Waller*, 906 F.2d 985, 993 (4th Cir. 1990) (recognizing a federal common law of unjust enrichment under ERISA, holding that ERISA Section 403(c)(2)(A), 29 U.S.C. § 1103(c)(2)(A), "indicates a desire to ensure that plan funds are administered equitably and that no one party, *not even plan beneficiaries*, should unjustly profit").

## IV. CONCLUSION

Eliminating the capacity of employee benefit plans to be reimbursed for monies expended on behalf of individual plan participants and beneficiaries out of those individuals' third-party recoveries inevitably increases costs for the plans as well as fellow plan members. This creates unfortunate disincentives to the creation of ERISA plans at a time when the United States' voluntary, employer-sponsored health care system is struggling with rising health care costs.

For the above reasons, *Amici* the American Association of Health Plans, the American Benefits Council, the Blue Cross Blue Shield Association, the Chamber of Commerce of the United States, and the Health Insurance Association of America respectfully request that this Court reverse the decision of the Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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